DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/SUP

accepted .

PRINTED: 09/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN' AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF F	ROVIDER OR SUPPLIER	110230		STR	REET ADDRESS, CITY, STATE, ZIP CODE	09/0	6/2012
FAIRPA	RK HEALTHCARE CE	NTER .		3	07 N FIFTH ST BOX 5477 MARYVILLE, TN 37801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	uld be	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	(F 0	00}	This Plan of Correction is the center's cred allegation of compliance.	ible	
	were completed at September 6, 2012 Allegation of Comp Immediate Jeopard and Severity level "and F-520, Scope a revisit revealed the implemented Augustammediate Jeopard continues at a "D"	st 30, 2012, removed the ly, but non-compliance evel Scope and Severity for and at an "E" level for F-223,			Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed sole it is required by the provisions of federal and	t by the conclusions he plan of sty because	
(F 157) SS=D	The facility is required correction for the last lowered in scope at 483.10(b)(11) NOT (INJURY/DECLINE)	IFY OF CHANGES	{F 1	57]		•	
	consult with the residence consult with the resident involving the injury and has the properties of a significant of the consequences, or to treatment; or a decident involving the consequences, or to the resident from the §483.12(a).	ediately inform the resident; ident's physician; and if sident's legal representative nily member when there is an ne resident which results in totential for requiring physician ficant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial hreatening conditions or as); a need to alter treatment need to discontinue an atment due to adverse a commence a new form of elsion to transfer or discharge e facility as specified in			F157-It is the practice of this facility to immotify the attending physician of a significant a resident's physical, mental or psychosocial requiring physician intervention. Immediately after Resident #1 communicate allegation of rape on June 16 the facility not physician. The physician ordered the resider to the emergency room at the local acute car which was done. On August 16, 2012 the covering physician resident's attending physician, who was on vws contacted and requested to write orders following lab tests. HIV, Hepatitis ABC server RPR. Those tests (HIV, Hepatitis ABC server obtained and the results returned negations.)	ot change in I status Istatus It the iffied the it to be sent to hospital, for the mestion, for the sen, and	9/13/12
ABORATORY	<i>V</i> .	ER/SUPPLIER REPRESENTATIVE'S SIGN		1.	TITLE	QL	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA · IDENTIFICATION NUMBER:	I, ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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	ROVIDER OR SUPPLIER RK HEALTHCARE CE SUMMARY STA	NTER TEMENT OF DEFICIENCIES	ID	30	EET ADDRESS, CITY, STATE, ZIP CODE 07 N FIFTH ST BOX 5477 IARYVILLE, TN 37801 PROVIDER'S PLAN OF CORRECT		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 157}	The facility must als and, if known, the re or interested family change in room or a specified in §483.1 resident rights under regulations as specified this section. The facility must rethe address and phelegal representative. This REQUIREMENT by: Based on medical facility investigation forensic report, obstacility failed to imma positive finding received. The facility failed to imma positive finding received. The facility hysician immediate from being able to sthe Resident's Family treatment for sexua (STDs) that may has the assault, for one Resident's reviewed Immediate Jeopard provider's noncomprequirements of par	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or iffied in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. It is not met as evidenced record review, review of the review of a sexual assault ervation, and interview, the rediately notify the Physician of ported to the facility on August ual assault forensic report leged rape on June 16, 2012, 1) of twelve Residents ity's failure to notify the ely prevented the Physician speak with the Resident and/or ily about treatment or potential ly transmitted diseases we been transmitted during Resident (#1) of twelve 1, placing Resident #1 in y (a situation in which the liance with one or more ticipation has caused, or is ous injury, harm, impairment,	{F 1:	57)	This Plan of Correction is the center's creatilegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged on set forth in the statement of deficiencies. I correction is prepared and/or executed so it is required by the provisions of federal as sexual transmitted diseases. The resident's was on vacation from August 11 and return August 19. Resident #1 attending physicial notified by the Administrator on August 19 test results SAFE kit conducted at the hospit Resident #1 was discharged from facility or 2012. The MDS Coordinator and the Unit Secretal direction of the Director of Nursing, conducted and idagnostic tests ordered for current in tesidents, the audit was conducted from #22 diagnostic tests completed since June 15, 20 audit was performed to validate that the physican notified in a timely manner as per regulability policy. The facility found that all labean reported timely to physicians An addit was conducted by the Staff Development Coordinator on \$123/2012 to ensure that famphysicians had been notified of all events on from 6/15/2012 to 8/22/12 and no issues no As of August 27, 2012 all licensed nurses at the facility, received in-service education of for Physician Notification for lab results or Vita including but not limited to diagnostic test events, and resident significant change in complete additional physician notification information ordered freatment changes, and family notificational physician notification information ordered freatment changes, and family notificational physician notification information ordered freatment changes, and family notificational physician notification information ordered freatment changes, and family notificational physician notification information ordered freatment changes, and family notificational physician notification information ordered freatment changes, and family notification and diagnostic test log which has been report, new particular physicians as per regulatio	of correction at by the renclusions. The plan of lely because and state law, physician and state law, and state an audit phonose. The stein had that one and the louse and the state an audit phonose and the state	

A BUILDING A BUILDING R-C 09/06/2 NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A BUILDING RECOMPLETE A BUILDING RECOMPLETE A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG RECOMPLETE COMPLETE COMPLETE R-C 09/06/2	
NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
The facility provided a Credible Allegation of Compliance on August 30, 2012. A revisit conducted on September 6, 2012, revealed the corrective actions implemented on August 30, 2012, removed the Immediate Jeopardy. Non-compliance for F-157 continues at a "D" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, facility policy review, in-service reviews, and interviews with facility staff, including administrative staff. Resident #1 was discharged to another facility on August 16, 2012. The facility provided evidence the on-call Physician was notified on August 17, 2012, and ordered testing for sexually transmitted diseases (STD's), to include HIV (Human Immunodeficiency Virus); Hepatitis A, B, and C; and RPR (Rapid Plaema Reagin). The tasts were completed on August 17, 2012, and were negative. The facility provided evidence of reviews of diagnostic test completed since June 15, 2012, to ensure the Residents' Physician had been notified in a timely manner. The facility provided evidence of the revised policy, Notifications, to ensure the Residents' policy for the service of the substance of the substance and the context and the context and the context and the context and the left of the substance and the context and state law of the substance of th	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
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{F 223}	testing results. The facility provided related to policies a for Physician Notific and diagnostic testi offsite diagnostic diagnos	d evidence of in-services and procedures for Guidelines eation of Change in Conditioning, including in-house and sts. Itom facility licensed nursing for facility licensed nursing for fursing, and the gothe revisit, confirmed they vices related to Guidelines for on of Change in Condition and ons. Out of compliance at a "D" is an acceptable plan of accility's corrective measures and evaluated by the Quality mance Improvement It is right to be free from verbal, differential abuse, corporal voluntary sectusion. It use verbal, mental, sexual, orporal punishment, or n. It is not met as evidenced	{F 2		This Plan of Correction is the center's creditallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed solid it is required by the provisions of federal and the interest and involuntary acclusion. On August 3, 2012 the facility was informed allegation of rape made in June by Resident now being considered as possibly having on to the results of the forensic testing. Resident discharged from facility on August 16, 2012 was conducted VP of Clinical Ops on August of all events occurring from January 1, 2012 30, 2012, no other allegations of sexual abuse reported. An additional audit was conducted Staff Development Co-coordinator on 8/23/ctsure that families and physicians had been all events occurring from 6/15/2012 to 8/22/issues noted	t is free from corporate d that the # 1 was curred due u # 1 was curred	9/13/12
	based on medical refacility investigation,	ecord review, review of the review of facility training					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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{F 223}	hours, review of an a sexual assault for interview, the facility Resident (#1) with a common type of Demental ability is sen normal activities of of twelve Residents to prevent sexual a immediately implent residents from the reoccurring placed Immediate Jeopard provider's noncomprequirements of partikely to cause, serior death to a Resident of the facility provider Compliance on Aug conducted on September 2012, removed the Non-compliance for level citation (potential). The findings include Validation of the CreCompliance was accepted to the conducted on September 2012, removed the Non-compliance for level citation (potential).	facility policy, review of payroll interview schedule, review of rensic report, observation, and y failed to protect one Alzheimer's Disease (a ementia, in which a loss of vere enough to interfere with daily living) from sexual abuse a reviewed. The facility's failure buse and failure to nent interventions to protect potential of the abuse all Residents with Dementia in the liance with one or more ricipation has caused, or is ous injury, harm, impairment, ent). If a Credible Allegation of gust 30, 2012. A revisit ember 6, 2012, revealed the implemented on August 30, Immediate Jeopardy. F-223 continues at an "E" tital for more than minimal ed: edible Allegation of complished through medical invation, facility policy review, and interviews with Residents, and administrative staff and	{F 223}	This Plan of Correction is the center's creatallegation of compliance. Freparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencles. To correction is prepared and/or executed solid it is required by the provisions of federal or interviewable residents were questioned by Administrator, Director of Nursing, Assistant of Nursing, Staff Development Coordinator, Office Manager, Activity Director, Director Services, Admissions Coordinator, Director Services, Admissions Coordinator, Director Records, Infection Preventionist, Certified It Manager, Case Manager, MDS Coordinator, Tech (Certified Nursing Asst), between Aug August 2B, to determine the following: if the further allegations related to staff treatment, residents witnessed any unusual visitors, staff had concerns about any staff members. The did not produce any other allegations of sexuance provide any potential leads for suspects, understanding of the Executive Director from department that the facility was to refrain from the trief of the treatment of the manager of the person to question male comployees and procure DNA samples. The padvised the facility that in doing so it may in interfere with law enforcement's ability to co-conduct its criminal investigation and to identified the facility with the request of the local police and based on policy and procedure of the facility "Responding to and Investigating an Abuse A The interdisciplinary team consisting of MD coordinator, RN Case manager, Director of S Services, Activity Director, Registered Dietic Certified Dictary Manager identified the residence in the reliability of the prevention of abuse. This increased focus	the conclusions the plan of sly the conclusions the plan of sly because and state law. The plan of sly because and state law. The plan of Social of Medical bietary and Rehabust 23 and the were any did had ingers or interviews all abuse. It was the no the police of t	

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August 16, 2012. The facility provided families of non-interviewed for alleged. The facility provided Team assessed, id plans of Residents for abuse. The Resident Court were discussed. The facility provided background checks with no negative find background checks out-of-state resident confirmed the result. The facility provided interim security per 2012, through Sept around-the-clock seeffective September does not identify a total the facility provided Abuse Prohibition. The facility provided Workgroup had been seed for alleged workgroup had been seed for a	d évidence Residents and erviewable Residents were gations of abuse; no abuse devidence the Interdisciplinary lentified, and updated care who may be at a higher risk and male staff except two dings. The delay in the two is is due to previous and the Administrator lits are expected at any time. It would be effective August 30, tember 4, 2012. A contract for ecurity personnel was obtained er 5, 2012; and the contract	{F 223}	This Plan of Correction is the center's creditallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed solid it is required by the provisions of federal as communicated to the Certified Nursing Assiviatheir assignment sheet and by placing a resident care plan for higher risk of potential "Social Isolation" in the C.N.A flow sheet be Licensed nurses have a copy of the resident for higher risk of potential abuse, "Social Is the resident's Medication Administration Reference in the resident's Medication Administration Reference in the resident of the resident of the resident for higher risk of potential abuse, "Social Is the resident's Medication Administration Reference in the resident of the resident for higher risk of potential abuse, "Social Is the resident's Medication Administration Reference and Director of Social Conducted a Resident Council meeting on 8 discuss any security concerns of the resident this meeting the residents indicated to the Athat they felt safe here. The corporate Hurman Resource department updated background checks on all male employees. Used to identify any current issues. Usedground checks on all male employees June 15, 2012 has been completed and all a negative. A security assessment was completed on 8/police officer of the City of Maryville. The conducted a tour of the facility as well as it the facility. A verbal recommendation from was for the facility to hire a security guard outcome of the police investigation around enhance the facility to hire a security guard outcome of the police investigation around enhance the facility to hire a security working taken into castedy. The center has obtained because in the performance Improvement County Sheri Department starting 8/30/12 until a replace contract is obtained. The facility will recompared to the Performance Director, Administrator, Nursing,	of correction of by the conclusions the plan of the pl	

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Obsert Admir Residipotent Obsert Flows care pabuses Obsert securit breaks Visitor log up exit. Visitor log up exit. Visitor lobby made and out confirmensure discovillation of the confirmensure of th	vation of the heet book cor- lans who are vation of the heet book cor- lans who are vation of the from the from the from the from the courty around the butside of the courty around the butside of the coned routine, the a pattern is ered by a policy vation of the capter of the core open the do Review of the check of the sheets ling to policy.	ege 6 100 hall Medication ord confirmed a copy of ns who are at high risk for Certified Nursing Assistant infirmed a copy of Residents' at high risk for potential front lobby confirmed a constantly present except for covered by facility staff. ved to sign-in on the visitor's ne facility; and sign-out upon nt door is locked down, .m., the security guard makes bunds inside from the front and door, outside rounds are uilding, to include the inside countyard. The security guard timed, rounds are avoided, to not established and tential perpetrator. service hall entrance se were locked and required ors for vendors from the ne vendor sign-in sheets were being completed courtyard door confirmed to enter and exit. Continued ted staff covered the code pad ized individuals from obtaining	{F 2	23}	This Plan of Correction is the center's crediallegation of compilance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and Relations Coordinator Pacility policies and procedures were review Administrator, Director of Nursing and Distrectional Operations on 8/30/12. Two minore were made to the written policy and procedurs/21/12 an Addendum to Facility's Abuse Preolicy and Procedures was made to clarify the "visitors" to include both family/friends as well-induced to: Paramedics, EMT's, Radiological laboratory techs, Physicians, Nurse Practition attorneys, and legal representatives On 8/30/12 policy on "Notification" was amended to addephysicians will be notified for lab test results test results returned from another laboratory healthcare site that the resident was seen. The Administrator conducted in-services for facil definitions of abuse, recognizing signs of possibles, protection of resident, Elder Abuse Administrator conducted beginning on 7/3/1/12, 8/9/12, 8/22/12 and 8/24/12 for facil Staff who are on leave, PRN, etc. will not be return to work until receiving the same in-servine comprehensive practice for alleged abuse will include documentation of the investigation "Alleged Abuse Investigation Worksheet". Two resident and contacts the Administrator and I Nunces who will return to the center to conduit the Administrator or Director of Nursing available to conduct the investigation immediately ensures the safety resident and contacts the Administrator and I Nunces who will return to the center to conduit the investigation immediately ensures the safety resident and conduct the investigation immediately ensures the safety resident and conduct the investigation immediately ensures the safety resident and conduct the investigation immediately ensures the safety resident and conduct the in	f correction by the conclusions to plan of ly because and state law. ed by the ict Director changes res. On ohibition te term rell as other ut not l'Techs, ners, clergy, 2012 the l that le or other of the ity staff on ssible ct. These Of/12, lity staff, allowed to rvice c events on on the his sits all liews, and om a re- abuse, the y of the Director of tet the the event the step to liately, the tot Director tot Director tot Director	

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{F 223}	Observation of the three carmeras were activity from the (1) entrance, and the (1) recording device ar front business office evidence recording compliance with the requirements (at the Observation of rand confirmed wooden window thresholds. The facility provided related to policies a security measures; definitions of abuse possible abuse, pro Abuse Act; and related to knowle worksheets. Interviews with rand revealed no knowle Abuse. Interviews with rand certified nursing state staff, the Director of Administrator, during had received in-semprocedures for update Abuse, including the recognizing the sign protection of Reside related documentation.	camera monitor confirmed in operation and recording front entrance, (2) service hall front entrance, (2) service hall so employee locker room. The ind monitor is positioned in the ear. The facility provided is are reviewed daily, to ensure existor and vendor sign-in/out efront and service hall doors). However, and the foodeter outside entry. However, including the evidence of in-services and procedures for updated Abuse, including the recognizing the signs of tection of Residents; the Elder sted documentation and how facility licensed and finding and finding in and the general the policies and interest security measures; a definitions of abuse, ands; the Elder Abuse, ints; the Elder Abuse Act; and interest the	{F 2	223}	This Plan of Correction is the center's callegation of compilance. Preparation and/or execution of this plandoes not constitute admission or agreem provider of the truth of the facts alleged set forth in the statement of deficiencies, correction is prepared and/or executed it is required by the provisions of federal this required by the provisions of federal investigators on proper completion of this On August 6 the facility convened a Per Improvement Security Workgroup meeting members of the Security Workgroup are: Director (Plant Ops Manager), Administ of Nursing, Activity Director, Staff Deve Coordinator, Housekeeping Supervisor of Nursing, Activity Director, Staff Deve Coordinator, Housekeeping Supervisor enhanced security measures that could be were identified. The lock codes were changed on 8/27/main entrance, fixit codes were also changed overy 30 days or more frequent compromised. The court yard gate will rail times unless under direct observation bring in or remove materials such as law equipment, yard debris, etc. The mainten or maintenance assistant will be responsible for having the responsible for having the maintenance and Administrator has key. The service door, which is for staff access only, is locked 24 hours a day/7 of Staff may use access code to exit and en Vendors/delivery personnel must ring be staff open the door. The staff who open responsible for having the vendor sign. The vendor sign in sheet is located at the entrance. The Administrator, Maintenan Director of Nursing, Business Office M Director of Nursing ar assigned weeken managers will monitor the vendor logs that vendors are signing in and out. Winserens were checked from the exterior 2012 and found to be secure by the main entrance. The definition the secure by the main entrance were checked from the exterior 2012 and found to be secure by the main entrance.	an of correction ment by the lar conclusions. The plan of solely because at and state law. Is conducted an potential is worksheet, formance ing. The Maintenance rater, Director clopment and Customer. At this meeting e put in place. 2012 for the ce and the court aged and are as will be lay if the code is emain locked at i.e., opened to meare hance director in the continue of the code is emance of the continue	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/10/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING R-C B. WING _ 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH SY BOX 6477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S FLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE ..TAG.. DATE DEFICIENCY) F223 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. director. To make resident room windows so that they cannot be opened from the outside by an "intruder. wood dowels were placed in the inside slides track to prevent the windows opening greater than 6 inches on August 14, 2012. The facility has purchased windows locks for the resident room windows and after approval from the State of Tennessee, Dept. of Health, Health Care Facilities Engineering were installed on 9/13/2012. All non-resident room windows are currently secured by an inside lock. The maintenance director, maintenance assistant, assigned week-end duty manager are checking the resident room windows daily to validate the current safety device is in place. Currently there are 3 camera's attached to a motion detector that records when there is movement detected. The cametas visualize the front entrance (camera installation 8/10/2012), the vendor entrance (camem installation began 8/30/2012 and completed 8/31/2012), and the employee locker mom (camera installed in 2010). This recording will provide the facility with evidence to review if there are any events such as employee theft, or other events that occurred, its intent is not to use as real time monitoring but provide a retrospective review. This is another mechanism for monitoring the compliance of the visitor and vendor sign in/out procedure. Results of daily review of the recordings will be reported in the weekday morning meeting. At the present time it is reviewed daily by the maintenance director (Plant Ops Manager), or the Administrator, Director of Nursing, Assistant Director of Nutsing, Business Office Manager, 3 Business Office Assistants, Activity Director, Activity Assistant, Director of Social Services, Director of Admissions,

'ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRB812

Facility ID: TN0508

Director of Medical Records and Data Entry Clerk, It is possible to watch the camera real time if circumstances warrant. The front entrance is tocked down beginning at 6 pm. Visitors must ring the bell and security personnel or staff respond to allow visitors to enter and exit the facility. A "visitor's log" placed at the receptionist area

If continuation sheat Page Say 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/10/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING R-C B. WING 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (XS) COMPLETION PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION). ..TAG.. CROSS-REFERENCED TO THE APPROPRIATE DATE _DEFICIENCY)_____ Carried Sec. F223 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions sat forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is regulred by the provisions of federal and state law, is monitored by video cameras, facility staff and/or the security guard to ensure that visitors sign in and out. The Administrator conducted in-services for staff on the facility's updated security measures on August 18. 19, 21, 23, 24, and 28, 2012. Employees on leave of absence, vacation, etc. upon return will receive the same in-service on prevention measures by their department head or designee, prior to reporting to their job area. On August 23, 2012 the District Director of Clinical Ops conducted additional in-service training with Administrator, Director of Nursing, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst. Director of Nursing on "Conducting an Investigation on an Allegation of Abuse" which included, but was not limited to, immediacy of investigation, notifications, interviewing alleged victim, alleged perpetrator, interviewing witnesses including staff, residents, family members, etc. The maintenance director, Administrator, Business of Manager or assigned weekend duty managers will be responsible to view the video taping of the front labby, the employee locker room and the verklor entrance and report any concerns to the facility administrator daily, Any staff member not in compliance with enhanced accurity measures will be disciplined as appropriate. New hires will receive facility orientation to the centers enhanced security measures. The Facility's Performance Improvement Committee

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XR8812

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Facility ID: TN0503

(Administrator, Director of Nursing, Medical Director, Asst. Director of Nursing, Staff Development Coordinator, Business Office Manager, RN Case Manager, MDS Coordinator, Activity Director, Director of Social Services, CDM, Plant Ops Manager) met on August 21, 2012 to address issues of accurity. Updates to the security measures will be provided, effectiveness

Administrator/Director of Nursing/Staff Development

of measures will be reviewed and further recommendations made as needed. The

If continuation sheet Page 80 423

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/10/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C 8, WING 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET-ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION). PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID ш (X5) COMPLETION DATE PRÉFIX PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F2Z3 This Plan of Correction is the center's credible allegation of compilance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law, Coordinator will track and trend events such as injusy of unknown origin, information from resident/family interviews and allegation of abuse investigations, if any, to monitor and evaluate facility's abuse prevention program The Director of Nursing will continue to present to the Facility Performance Improvement Committee at its monthly meeting any/all investigations of allegations of abuse that includes a review of compliance with the facility's P&P on Abuse Prevention & Investigation for review, discussion and recommendations, if indicated.

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Event ID: XRB812

Facility ID: TN0503

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	The facility provided Compliance on Aug conducted on Septic corrective actions it 2012, removed the Non-compliance for level citation (potential). The findings included Validation of the Corrective was accord review, obsein-service reviews, facility staff, including security guard staff Resident #1 was displayed and the facility provided families of non-interinterviewed for allegwas alleged. The facility provided Team assessed, ide	d a Credible Allegation of gust 30, 2012. A revisit ember 6, 2012, revealed the implemented on August 30, Immediate Jeopardy. If F-226 continues at an "E" trial for more than minimal ed: edible Allegation of ecomplished through medical ervation, facility policy review, and interviews with Residents, no administrative staff and	(F 226)	This Plan of Correction is the center's credicallegation of compliance. Preparation and/or execution of this plan of does not constitute admixtion or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed sole it is required by the provisions of federal and advised the facility that in doing so it may in interfere with law enforcement's ability to occonduct its criminal investigation and to idee prosecute the perpetrator. The facility agree comply with the request of the local police a based on policy and procedure of the facility "Responding to and Investigating an Abuse The interdisciplinary team consisting of ME coordinator, RN Case manager. Director of Services, Activity Director, Registered Diet Certified Dietary Manager identified the rest 8/29/2012 that may be at higher risk for abuse dementia diagnosis, infrequent or no visitor issues, or those who are bedfast and depend The interdisciplinary team met on 8/29 throst identify care plan goals and interventions the prevention of abuse. This increased for residents who may be at higher risk for abuse communicated to the Certified Nursing Assivia their assignment sheet and by placing a resident care plan for higher risk of potentia "Social Isolation" in the C.N.A flow sheet be Licensed nurses have a copy of the resident for higher risk of potential abuse, "Social is the resident's Medication Administration R. The Activity Director and Director of Social conducted a Resident Council meeting on 8 diacuss any security concerns of the resident this meeting the residents indicated to the Athat they felt safe here. The corporate Human Resource department updated background cheeks on all male employees in the prevention of checks on all male employees.	f correction by the conclusions of plan of the plan of	
-	The facility provided evidence of updated background checks on all male staff except two, with no negative findings. The delay in the two background checks is due to previous			6/15/2012 has been completed and all areas negative. A security assessment was completed on \$4 police officer of the City of Maryville. The conducted a tour of the facility as well as the security of the s	30/2012 by a	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
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{F 226}	out-of-state resident confirmed the result the result The facility provided interim security personal to the facility provided set of sective September does not identify a total the facility provided Abuse Prohibition. The facility provided Workgroup had been thanced security rimplemented. Observation of the Administration Reconstitution of the Administration Reconstitution of the Administration of the Administra	ces, and the Administrator its are expected at any time. Sevidence of around-the-clock sonnel effective August 30, ember 4, 2012. A contract for ecurity personnel was obtained in 5, 2012; and the contract ermination date. If evidence of a revised policy, it evidence a Security en developed to ensure measures were identified and	{F 2	26}	This Plan of Correction is the center's creditallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed sole it is required by the provisions of federal and the facility. A verbal recommendation from was for the facility to hire a security guard poutcome of the police investigation around the enhance the facility's security measures survisitors sign in/out procedures, and provide security support until a perpetrator is identified to the facility of the Blount County Sheriff Department starting 8/30/12 until a replacementate is obtained. The facility will recomperformance Improvement security workground the Performance Improvement Committee and action. The members of the Security are: Maintenance Director, Administrator, Incompeted and actions Coordinator and procedures were review Administrator, Director of Nursing and Discusing, Activity Director, Staff Development Conditions Coordinator Facility policies and procedures were review Administrator, Director of Nursing and Discusing Administrator, Director of Nursing and Discusing Administrator, Director of Nursing and Discusional Consultants or visitors such as limited to: Paramedies, EMT's, Radiological laboratory techs, Physicians, Nurse Practition of "Notification" was amended to applysicians will be notified for lab test result test results returned from another laboratory healthcare site that the resident was seen. Administrator conducted in-services for fac definitions of abuse, recognizing signs of painese, protection of resident, Elder Abuse, protection of resident, Elder Abuse	correction by the conclusions to plan of ly because d state law. The officer ending the he clock to bounding additional ied and security fent security vene the up at that resent them of for review orkgroup director of ent Patient Patient Ved by the rict Director changes ures. On robibition he term well as other but not al Techs, oners, clergy, 1/2012 the id that the or other refility staff on ossible Act. These 30/12, cility staff.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		iple construction ig	(X3) DATE SI COMPLE	
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	and outside of the confirmed routine, I ensure a pattern is discovered by a policy. Observation of the confirmed the doors staff to open the doinside. Review of the revealed the sheets according to policy. Observation of the codes are required observation confirm to prevent unauthor the code. Observation of the confirmation that code are required observation of the code three cameras were activity from the (1) entrance, and the (2) recording device an front business office evidence recordings compliance with the requirements (at the Observation of rand-confirmed wooden of window thresholds to The facility provided related to policies are security measures; Adefinitions of abuse, possible abuse, prot	courtyard. The security guard timed, rounds are avoided, to not established and tential perpetrator. Service hall entrance is were locked and required fors for vendors from the ne vendor sign-in sheets is were being completed. Courtyard door confirmed to enter and exit. Continued ned staff covered the code paddized individuals from obtaining front entrance, (2) service hall is employee locker room. The different and service daily, to ensure exister and vendor sign-in/out in front and service hall doors). Com Residents' rooms lowels were present in the order outside entry. evidence of in-services and procedures for updated	{F 2	26}	This Plan of Correction is the center's concilegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies. correction is prepared and/or executed set it is required by the provisions of federal return to work until receiving the same in-The comprehensive practice for alleged ab will include documentation of the investig "Alleged Abuse Investigation Worksheet" worksheet identifies actions taken to prevent resident occurrence. Upon notification of an allege licensed nurse immediately ensures the saft resident and contacts the Administrator and Nurses who will return to the center to continvestigation and utilize this worksheet. I return the Administrator or Director of Nurses, the RN Case Manager, MDS conditable to conduct the investigation immediately ensures the Director of Social Services. The District Director of Social Services on Algorithm Relations of Nursing, Activity Director, Staff Develo Coordinator, Housekeeping Supervisor and Service (Patient Relations) Coordinator. At enhanced security mensures that could be power identified. The lock codes were changed on 8/27/20 main entrance, the vendor/service entrance yard entrance, Exit codes were also changed different than entrance codes. Door codes we changed every 30 days or more frequently if compromised. The court yard gate will remail times unless under direct observation i.e. bring in or remove materials such as lawn coupriment, yard debris, etc. The maintenance maintenance assistant will be responsible	a of correction and by the proconclusions. The plan of colely because and state low. Service . we events atton on the This lists all erviews, and from a red abuse, the fety of the d. Director of abuse, the fety of the d. the event mg are not ediately, the stant Director ordinator conducted an etertial worksheet. The faintenance or, Director prinent Customer this meeting and the court d and are will be if the code is ain locked at opened to ease director end directo	

STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		IPLE CONSTRUCTION 4G	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
			F-2.2	6	This Plan of Correction is the center's a allegation of compliance. Preparation and/or execution of this plat does not constitute admission or agreen provider of the truth of the facts allegat set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal unlock/lock and monitor gate during this activity. The key is secured in the mainted Only Maintenance and Administrator has key. The service door, which is for staff access only, is locked 24 hours a day/7 of Staff may use access code to exit and entitle Vendors/delivery personnel must ring be staff open the door. The staff who opens responsible for having the vendor sign-in The vendor sign in sheet is located at the entrance. The Administrator, Maintenance Director of Nursing or assigned week-end managers will monitor the vendor logs dathat vendors are signing in and out. Wind screens were checked from the exterior or 2012 and found to be secure by the maintenance were checked from the outside hy an wood dowels were placed in the inside slip stevent the windows opening greater than August 14, 2012. The facility has purchas locks for the resident room windows and from the State of Tennessee, Dept. of Hea Care Facilities Engineering were installed All non-resident com windows are curred by an inside lock. The maintenance direct maintenance assistant, assigned week-end are checking the resident room windows are curred by an inside lock. The maintenance direct maintenance assistant, assigned week-end are checking the resident room windows and the chief the current safety device is in plat Currently there are 3 cancers's attached to detector that records when there is movem The cameras visualize the front entrance (cinstallation 8/10/2012), the vendor entrance installation began 8/30/2012 and complete and the employee locker toom (carners installatione to review if there are any events a camployee theft, or other events that occurred	an of correction nent by the lar conclusions. The plan of solely because at and state law type of mance office, we access to the fand vendor ays a week. etr. Il and have the door is and sign out. delivery a Director, agent, Asst. I duty lily to ensure ows and a Aug 16, enance as so that they lily to ensure ows and the plant of the confer approval lith, Health on 9/13/2012, mily secured tor, duty manager aily to co. a motion eatt detected, camera ad 8/31/2012), tailed in illicy with silver and the confer approval confer approval lith.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/10/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING R-C B. WING 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION). (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE . TAG., DATE ...DEFICIENCY) F226 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. is not to use as real time monitoring but provide a retrospective review. This is another mechanism for monitoring the compliance of the visitor and vendor sign in/out procedure. Results of daily review of the recordings will be reported in the weekday morning meeting. At the present time it is reviewed daily by the maintenance director (Plant Ops Manager), or the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, 3 Business Office Assistants, Activity Director, Activity Assistant, Director of Social Services, Director of Admissions, Director of Medical Records and Data Entry Clerk. It is possible to watch the camera real time if circumstances warrant. The front entrance is locked down beginning at 6 pm. Visitors must ring the bell and accurity personnel or staff respond to allow visitors to enter and exit the facility. A "visitor's log" placed at the receptionist area is monitored by video cameras, facility staff and/or the security guard to ensure that visitors sign in and out. The Administrator conducted in-services for staff on the facility's updated security measures on August 18, 19.21, 23, 24, and 28, 2012. Employees on icave of absence, vacation, etc. upon return will receive the same in-service on prevention measures by their department head or designee, prior to reporting to their job area. On August 23, 2012 the District Director of Clinical Ops

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRB812

Facility ID; TN0503

members, etc.

conducted additional in-service training with Administrator, Director of Nursing, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst. Director of Nursing on "Conducting an Investigation on an Allegation of Abuse" which included, but was not limited to, immediacy of investigation, notifications, interviewing alleged victim, alleged perpetrator, interviewing witnesses including staff, residents, family

The maintenance director, Administrator, Business of Manager or assigned weekend duty managers will be responsible to view the video taping of the front labby,

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{F 226}	immediacy of the ir interviewing; and reworksheets. Interviews with rand revealed no knowle Abuse. Interviews with rand certified nursing states staff, the Director of Administrator, during the director of the procedures for updates, including the	tinued From page 12 ediacy of the investigation, notifications, and viewing; and related documentation and caches. Views with random Residents and families alled no knowledge of and/or allegations of se. Views with random facility licensed and fied nursing staff, dietary and housekeeping, the Director of Nursing, and the ininistrator, during the revisit, confirmed they received in-services related to policies and edures for updated security measures; se, including the definitions of abuse, gnizing the signs of possible abuse. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provision of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		Correction by the conclusions te plan of ly because			
{F 250} \$\$=D	Conducting an Inverse of the investigation, interviewing; and reworksheets. The facility remains level until it provides correction and the faculd be reviewed a Assessment/Perfor Committee. 483.15(g)(1) PROV RELATED SOCIAL The facility must proservices to attain or	stigation, including immediacy notifications, and lated documentation and court of compliance at an "E" s an acceptable plan of acility's corrective measures and evaluated by the Quality mance Improvement ISION OF MEDICALLY SERVICE Evide medically-related social maintain the highest, mental, and psychosocial	⟨F 25		F250 - Resident #1 was discharged from the a August 16, 2012. The facility Director of Soc Services initially met with Resident #1 on Jun approximately 11am. The facility Social Serv Director continued to visit resident as well as direct care staff who cared for resident at leas week for 2 weeks (this is not documented but interview with the Director of Social Services Resident #1 to monitor for any changes of the behaviors in conjunction with the daily monit the nursing staff. Resident #1 was not assessed.	ial ne 18 st rices talk with st 2 times a based on to 10	9/13/12

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	by: Based on medical ifacility investigation, review of a sexual at Kit), review of a facility policy, and improvide medically-reflected the provide medically-related so the provider's nonconfequirements of partikely to cause, series or death to a Resider Compliance on Aug conducted on Septe corrective actions in 2012, removed the Information (potent harm). The findings include Validation of the Crecompliance was accrecification (potent harm).	record review, review of the review of facility policy, assault forensic report (Rape lity training program, review of a lated social services for one an allegation of sexual assault, reviewed. The facility's lity policy to provide locial services placed Resident opardy (a situation in which ompliance with one or more ticipation has caused, or is lous injury, harm, impairment, ent). If a Credible Allegation of lust 30, 2012. A revisit ember 6, 2012, revealed the inplemented on August 30, immediate Jeopardy. F-250 continues at a "D" lial for more than minimal discussion.	{F 2	50)	This Plan of Correction is the center's creatilegation of Compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged of set forth in the statement of deficiencies, correction is prepared and/or executed so it is required by the provisions of federal any changes or decline in hor mental or psy well-being up to and including her day of of from the facility on August 16, 2012. Resident #1 was visited by the by the consepsych Licensed Clinical Social Worker (LC June 18, 2012 and the resident declined to an interview discussing the alleged incident of (Licensed Clinical Social Worker) LCS assessment was that the Resident #1 had no behaviors or mood at this point. After disce the Administrator and Director of Social Swas decided that the LCSW (Licensed Clin Worker) would not further address the allegabuse with Resident #1 maleas she wished to Resident #1 had been assessed to have charant behavior. An audit was conducted by VP Clinical Op 30, 2012 of all events occurring from Janua August 30 2012, no other events of alleged had occurred. Interviewable residents were questione Administrator, Director of Nursing, Assists of Nursing, Staff Development Coordinator (Certified Mursing Assist; Development Coordinator of Nursing, Assists of Nursing, Staff Development Coordinator, and Reh (Certified Nursing Assist; Certified Dietary & Case Manager, MDS Coordinator, and Reh (Certified Nursing Assist; between August 2 August 28, to determine; if there were any allegations related to sinff treatment, did rethey were treated with respect, had resident any unusual visitors, strangers or had conciuny staff members? The interviews did not other allegations of sexual abuse nor give pleads for suspects. The facility did not reistaff members in August at the request of the police department. The interdisciplinary team consisting of Micoordinator, RN Case Manager, Social Worderdinator, RN Case Manager, Social Worderdinator, RN Case Manager, Social Worderdi	of correction on by the or conclusions. The plan of colely because and state law. The plan of colely because and state law. The plan of colely because and state law. The result with participate in the result with cole cole cole cole cole cole cole cole	
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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	•	445286	a. WIN	G		1	R-C
	PROVIDER OR SUPPLIER RK HEALTHCARE CE	NTER	-1.	307 N FIF	ORESS, CITY, STATE, ZIP CODE FTH ST BOX 5477 ILLE, TN 37801	0a/u	<u>16/2012</u>
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	families of non-interinterviewed for alleg was alleged. The facility provided Team, (including the assessed, identified Residents who may The facility provided related to policies a and Investigating ar related social work in response to alleg interview with the Direct received in-services procedures, Resport Abuse Allegation, and psychological services of abuse. The Direct revealed, "I have lead ensure all Residents receive the required services." The facility remains level until it provides correction and the facility remains all residents received and received	d evidence Residents and viewable Residents were gations of abuse; no abuse of evidence the Interdisciplinary e Director of Social Services), and updated care plans of the at a higher risk for abuse, and evidence of in-services and procedures, Responding to a Abuse Allegation, and and/or psychological services ations of abuse. Interception of Social Services and and and Investigating and related to policies and and related social work and/or set in response to allegations attor of Social Services are a lot through thisI will set with an allegation of abuse medically-related social cout of compliance at a "D" an acceptable plan of accility's corrective measures and evaluated by the Quality and evaluated by the Quality	(F 28	Prepides Prepides Prepides Prepides Prepides Provides Pro	Plan of Correction is the center's catalan of compliance. aration and/or execution of this plan not constitute admission or agreemider of the truth of the facts alleged orth in the statement of deficiencies, exciton is prepared and/or executed a required by the provisions of fadaration, Registered Dictician and Certification in the provisions of fadaration, Registered Dictician and Certification in the risk for abuse due to dementia duent or no visitors, behavioral insuctive bedfast and dependent on care. This is ciplinary team met on 8/29 through years plan goals and interventions into of abuse, agust 23 & 27, 2012 the District Dinal Ops conducted additional in-servicement, Activity Director, Social Worldoor Nursing Service, MDS Coordinator, Housekeeping and intervention of Nursing Service on "Conducting igation, notifications, interviewing a perpetrator if known, interviewing a perpetrator if known, interviewing ing staff, residents, family members true, etc which included the facility I. Services. On August 27, 2012 the Euro of Clinical Ops provided the Director of Social Service with additional in-service education of interviews, follow-up as fertals to physician and/or psychologiated. The Director of Social Service of m Nursing Service. The Director of the swill follow procedure for "Respongating an Abuse Allegation" when readured the investigation, residents and on the investigation, respectively.	n of correction ont by the corrections of conclusions. The plan of colely because I and state law. ed Dictary 2012 who are ingrass, s, or those he he B/30/12 to to assist in the cotor of ice training view of illeged victim, witnesses, family director of Social on on sessments, gical services a will be the reason of the cotor of interest of the reason of the cotor of ice training to and notified of an are referral to correct and correct of the correct	
{F 490}	Committee. 483.75 EFFECTIVE	RESIDENT WELL-BEING	{F 490	of the II docume	esident plan of care and communica DT at the meming meeting (Mon-Pentation of the resident's psychosociation by the clinical personnel, ministrator will munitor the Director	to to the rest ri), and ial status and	

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE S	ELED SUKVEA V. GROG-COR
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		v.,		Service's performance to valisocial services are provided to beginning 8/30/12 weekly X 4 X one quarter and then quarter allegation of abuse, the DNS documentation of the services Social Services during daily of that the psychosocial well being assessed, care planned and with appropriately implemented. The results of these audits will facility monthly Performance Concerns or recommendations Services documentation will be communicated by the administration will be communicated by the administration of the social services documentation will be communicated by the administration of the social services documentation will be communicated by the administration of the social services documentation will be communicated by the administration of the social services documentation will be communicated by the administration of the services documentation will be communicated by the administration of the services documentation will be communicated by the administration of the services documentation will be social services documentation will be communicated by the administration of the services documentation will be communicated by the administration of the services documentation will be communicated by the administration of the services documentation will be serviced as the services documentation will be serviced as the services documentation will be serviced as the serviced documentation will be serviced as the serviced documentation will be serviced as the serviced documentation will be serviced documentati	the facility residents weeks and then monthly rly. When there is an or ADNS will review the provided by Director of finical rounds to validate ng of the resident is being th interventions he administrator will Director of Social hly beginning 8/30/2012. It be reviewed at the Improvement meeting, on the Director of Social	
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enables it to use its efficiently to attain of practicable physica well-being of each i	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial	{F 490	Preparation and/or execution of this p does not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficiencie correction is prepared and/or execute it is required by the provisions of fede F490 - The facility is administered in a	lan of correction the to the the to the the to the	9/13/12
by: Based on interview physical plant, the farmanner to protect Alzheimer's Diseas Dementia, in which severe enough to irrof daily livling) from policies and proced investigating and irrinterventions to ensign from further abuse. The facility's failure one Resident (#1) a Residents at risk for placed all Residents Jeopardy (a situation noncompliance with participation has caserious injury, harm Resident). The facility provided Compliance on Aug conducted on Septe corrective actions in 2012, removed the livers and compliance for the livers are the serious for the livers are the serious in a conducted on Septe corrective actions in 2012, removed the livers are the serious for the seriou	V, and observation of the facility failed to administered in tone Resident (#1) with e (a common type of a loss of mental ability is interfere with normal activities sexual abuse; failed to ensure lures were followed for aplementing corrective sure Residents were protected of twelve Residents reviewed. The facility's failure is with Dementia in Immediate in in which the provider's none or more requirements of used, or is likely to cause, in impairment, or death to a la Credible Allegation of just 30, 2012. A revisit ember 6, 2012, revealed the applemented on August 30, Immediate Jeopardy. F-490 continues at an "E" tial for more than minimal		cnables it to use its resources effectivel to attain or maintain the highest practic mental and psychosocial well-being of On August 23, 2012 the Corporate Dis Clinical Operations and the Corporate Risk Management conducted training Administrator, Director of Nursing Set Coordinator, Director of Social Service Office Manager, Activity Director, RN Staff Dovelopment Coordinator, Admin Coordinator and the contract Housekee Supervisor on the corporate/facility pre investigating allegations of abuse. The procedures addressed were Respondin Investigating an Abuse Allegation, Co Investigation, and Protection of Reside Investigation. On August 27, 2012 the of Clinical Operations conducted the sthe Assistant Director of Nursing. Areas addressed included, providing protection to any resident involved in a immediate notification of the Adminis Director of Nursing Services, (or designanager i.e. Assistant Director of Nursing Coordinator, RN Case Manager. Director of Nursing Service), and notification of the physic The Administrator and Director of Nursing Investigation Worksheet". The Administrator and The Director of the Physic Investigation Worksheet". The Administrator and The Director of Clinical abuse allegation. The Administrator will call and update the Director of Nursing will call and update the report their findings and conclusion Nursing will call and update the Diversing will call and updat	y and efficiently able physical, each resident, rict Director of State Director of State Director of vith the vice, MDS as, Business Case Manager, ssions ping Services occlures for comprate to and aducting an at During An District Director ame training with immediate malleged abuse, rater and nated alternate sing, MDS tor of Social ian and family, see (or the facility to the facility to the facility of Nursing will Operations of the other the VP of stigntions status ion complete and ons. The Director	

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	o, solution	IDENTIFICATION NUMBER:	A. BUIL			COMPL	
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{F 490}	Continued From page 16 harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, in-service reviews, and interviews with Residents, facility staff, including administrative and security guard staff. Resident #1 was discharged to another facility			(0)	This Plan of Correction is the center's creatingation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement provider of the truth of the facts alleged of set forth in the statement of deficiencies, correction is prepared and/or executed so it is regulied by the provisions of federal of Clinical Operations of the abuse allegation at least every other day until investigation of and then will call and report their findings a conclusions. The District Director of Clinic Operations or VP of Operations will follow facility with with the experience.	of correction nt hy the r conclusions The plan of lely because and state law, investigation completed and al	
	The facility provider families of non-interinterviewed for allegwas alleged. The facility provided Team assessed, ideplans of Residents for abuse. The facility provided background checks with no negative fine background checks out-of-state residence onfirmed the result. The facility provided assessment comple police officer with resecurity guard, to provided.	es, and the Administrator is are expected at any time. evidence of a security ited on August 30, 2012, by a commendations to hire a povide additional security.			taking year within one week of reported co- review the written investigation. On August 3, 2012 the facility was informed allegation of rape made in June by Resident now being considered as having possibly oc- to the results of the forensic testing. Resident discharged from facility on August 16, 2012 was conducted by VP of Clinical Ops on Au 2012 of all events occurring from January 1 August 30 2012, no other events of allegad had occurred, An additional audit was condu- Staff Development Coordinator on 8/22/2011 that families and physicians had been notifice events occurring from 6/15/2012 to 8/22/12 a sease noted. Interviewable residents and families of non- interviewable residents were questioned by at Administrator, Director of Nursing, Assistant of Nursing, Staff Development Coordinator, Office Manager, Activity Director, Director Services, Admissions Coordinator, Director, Services, Admissions Coordinator, Director, Certified Di Manager, Case Manager, MDS Coordinator, Tech (C.N.A), between August 23 and August determine; if there were any further allegation to staff treatment, did residents feel they were with respect, had residents witnessed any unit visitors, strangers or had concerns about any a members. The interviews did not produce any allegations of sexual abuse nor give potential suspects. It was the understanding of the Exe- Director that the facility not re-interviews there.	d that the # I was curred due to # I was curred due to # I was An audit to the gust 30, 2012 to to to to the do fall and no to Director Business of Social of Medical ictary and Rehab et 28, to na related to treated sual staff y other Jeads for cutive	
	interim security pers	onnel effective August 30,		, ,	in August at the request of the local police dep The police advised the facility that in the	members partment.	[

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) å	JULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY	
MIND FUND	OF CORRECTION	IDENTIFICATION NUMBER:	A, BU			COMPLE	TED
		445286	B. Wi	NG_		j	8-C 6/2012
	ROVIDER OR SUPPLIER	NTER		3	REET ADDRESS, CITY, STATE, ZIP COD 07 N FIFTH ST BOX 5477 MARYVILLE, TN 37801		***************************************
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{F 490}	2012, through Septiaround-the-clock seeffective September does not identify at the facility provided Abuse Prohibition. The facility provided Workgroup had been hanced security rimplemented. Observation of the Administration Recognition abuse. Observation of the Conservation of the footbase. Observation of the footbase which are conservation of the footbase. Observation of the footbase which are conservation of the footbase. Observation of the footbase which are conservation of the footbase. Observation of the footbase which are conservation of the footbase which are considered by the footbase which are conservation, periodic rould be ginning at 6:00 purposed around the burned outside of the conservation of the conservation of the footbase which are conservations at 6:00 purposed around the burned outside of the conservation of the conservation of the footbase which are conservations at the footbase which	ember 4, 2012. A contract for ecurity personnel was obtained r 5, 2012; and the contract remination date. I evidence of a revised policy, and eveloped to ensure measures were identified and a confirmed a copy of me who are at high risk for continued a copy of me who are at high risk for continued a copy of Residents' at high risk for potential constantly present except for except by facility staff, and sign-out upon the door is locked down, and, the security guard makes and sinside from the front of door, outside rounds are aliding, to include the inside purtyard. The security guard med, rounds are avoided, to not established and	{F 4	(00)	This Plan of Correction is the center allegation of compilance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts allegate forth in the statement of deficience correction is prepared and/or execute it is required by the provisions of fed impede or interfere with correctly concriminal investigation in order to deter prosecute the perpetrator. The police of that this was now his investigation and the person to question male staff employing and procedure of the facility agreed to fithe request of the local police and didpolicy and procedure of the facility "R Investigating an Abuse Allegation. The interdisciplinary team consisting a coordinator, RN Case manager, Direct Services, Activity Director, Registered Certified Dictary Manager identified if 8/29/2012 that may be at higher risk for dementia diagnosis, infrequent or no vissues, or those who are bedfast and de The interdisciplinary team met an 8/29 identify eare plan goals and intervention prevention of abuse. This increased for who may be at higher risk for abuse has communicated to the Certified Nursing via their assignment sheet and by placinesident care plan for higher risk of pot "Social Isolation" in the C.N.A flow at Licensed nurses have a copy of the resident sheat and birector of Sconducted a Resident Council meeting discuss any security concerns of the rethis meeting the residents indicated to that they felt safe here. The corporate Human Resource departing the deckground checks on all male employ 6/15/2012 has been completed and all an engative, A security assessment was completed on all nalegative, A security assessment was completed on the certified and all an engative,	plan of correction seement by the ged or conclusions ies. The plan of ed solely because eral and state law, ducting the mine and officer indicated if he wanted to be oyees and procure utily comply with so based on tesponding to and of MDS or of Social I Dictician and he residents on or abuse due to isitors, behavioral pendent on care. I and \$/30/2012 to the sole and \$/30/2012 to	

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(F 490)	Observation of the confirmed the door staff to open the do the vendor sign-in swere being completed observation of the codes are required observation confirm to prevent unauthor the code. Observation of the chree cameras were activity from the (1) entrance, and the (2) recording device and front business office evidence recording compliance with the requirements (at the Observation of rand confirmed wooden of window thresholds to the facility provided was in-serviced relaprocedures for updated Abuse; Responding Abuse Allegation; the Conducting an Investigation of the Administrator receivant in the receivant of the Administrator receivant in t	service hall entrance s were locked and required ors from the inside. Review of sheets revealed the sheets ted according to policy. courtyard door confirmed to enter and exit. Continued and staff covered the code pad ized individuals from obtaining camera monitor confirmed in operation and recording front entrance, (2) service hall be employee locker room. The ad monitor is positioned in the care reviewed daily, to ensure existion and vendor sign-in/out the facility provided so are reviewed daily, to ensure the visitor and vendor sign-in/out the front and service hall doors). It widence the Administrator ted to policies and sted security measures; to and Investigating an the Elder Abuse Act; stigation; and Protection of a Investigation. It ministrator confirmed the ted in-services related to tres for updated security	{F 490	This Plan of Correction is the center allegation of compliance. Preparation and/or execution of this does not constitute admission or agrowtider of the truth of the facts alles set forth in the statement of deficient correction is prepared and/or execution is prepared and/or execution is prepared in the facility as we the facility. A verbal recommendation was for the facility to hime a security clock to better ensure that visitors we appropriately and provide additional center has obtained security personn Blount County Sheriff Department as a replacement security contract is obtained security exchange and present them to the Performance Improvides and present them to the Performance Committee for review and action. To Security Workgroup are: Maintenant Administrator, Director of Nursing, a Staff Development Coordinator, Hor Supervisor and Patient Relations Cooperations on 8/30/12. Two were made to the written policy and 8/21/12 an Addendum to Facility's A Policy and Procedures was made to a visitors to include both family/friend professional consultants or visitors all instead to: Paramedies, EMT's, Radii laboratory teehs, Physicians, Nurse Pattorneys, and legal representatives, in policy on "Notification", was amend physicians will be notified for lab testest results returned from another lab healtheart site that the resident was some Administrator conducted in-services definitions of abuse, recognizing signabuse, protection of resident, Elder A in-services were conducted heginnin 1/31/12, 8/9/12, 8/22/12 and 8/24/12 employees. Staff who are on leave, will not be allowed to return to work will not be allowed to return to work	is plan of correction rement by the orged or conclusions raies. The plan of uted solely because ideral and state law. It. The officer cill as the grounds of on from the officer guard around the ere signing in security. The el through the tarting 8/30/12 until tained. The facility provement security is recommendations of improvement he members of the ce Director. Activity Director, asskeeping procedures, On abuse Prohibition clarify the term is as well as other uch as but not iological Techs. Practitioners, clergy, On 8/30/2012 the ed to add that at results or other for facility staff on its of possible thus Act. These gon 7/30/12, for facility agation, PRN, etc.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING R-C B. WING 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE: ZIP CODE 307 N FIFTH ST BOX 5477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE .TAG.. _DEFICIENCY)_____ F490 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. same in-service. The comprehensive practice for alleged abuse events will include documentation of the investigation on the "Afleged Abuse Investigation Worksheet", This worksheet identifies details of the incident, lists all possible witnesses, documents witness interviews, and identifies actions taken to prevent resident from a reoccurrence. Upon notification of an alleged abuse, the licensed nurse immediately ensures the safety of the resident and contacts the Administrator and Director of Nurses who will return to the center to conduct the investigation and utilize this worksheet. In the event that the Administrator or Director of Nursing are not available to conduct the investigation immediately the back up investigators will include the Assistant Director of Nurses, the RN Case Manager, MDS coordinator and/or the Director of Social Services. The District Director Clinical Operations conducted an in service on 8/23/12 to the above listed potential investigators on proper completion of this worksheet. On August 6 the facility convened a Performance Improvement Security Workgroup meeting. The members of the Security Workgroup are: Maintenance Director (Plant Ops Manager), Administrator, Director of Nursing, Activity Director, Staff Development Chordinator, Housekeeping Supervisor and Customer Service Coordinator. At this meeting a discussion of enhanced security measures that should be put in place were identified. The lock codes were changed August 27, 2012 for the main entrance, the vendor/service entrance and the court yard entrance. Exit codes were also changed and are different than entrance codes. Door codes will be changed every 30 days or more frequently if the code is " compromised. The court yard gate will remain locked at all times unless under direct observation i.e., opened to bring in or remove materials such as lawn care

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XR8812

Facility ID: TN0503

If continuation sheet Page (4a425

equipment, yard debris, etc. The maintenance director or maintenance assistant will be responsible to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILOI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	/		Preparation and/or execution of thi does not constitute admission or og provider of the truth of the facts all set forth in the statement of deficien correction is prepared and/or exect it is required by the provisions of fe	reement by the eged or conclusions cites. The plan of the solety because	
			unlock/lock and monitor gate during activity. The key is secured in the monity Maintenance and Administrato key. The service door, which is for access only, is locked 24 hours a day Staff may use access code to exit and Vendous/delivery personnel must rin staff open the door, the staff that open responsible to have vendor sign in about delivery entrance. The Administrator Director, (Plant Ops Manager), Director, Ops daily to ensure that vend and out. Windows and serroms were exterior on Aug 16, 2012 and found maintenance director. To make resident room circtor, prevent the windows opening inches on August 14, 2012. The facility windows locks for the resident room approval from the State of Tennesses Health Care Facilities Engineering we 9/13/2012. All non-resident room currently secured by an inside lock. director, maintenance assistant, assig manager are checking the resident room currently secured by an inside lock. director, maintenance assistant, assig manager are checking the resident root to velidate the current safety device in Currently there are 3 camera's attach detector that records when there is more continued to the found of the same	sintenance office, r have access to the staff and vendor r/7 days a week. d enter. g bell and have rns the door is nd sign out upon t is located at the r, Maintenance ctor of Nursing, teter of Nursing or ll monitor the lors are signing in checked from the to be secure by the lent room windows the outside by an in the inside slides g greater than 6 ity has purchased windows and after c, Dept, of Health, tere installed on windows are The maintenance med week-end duty out windows deily s in place. ed to a motion overnent detected nec (installation ation began on d the employee s recording will review if there are r other events that	
M CMS-2587(02-99) Previous Versions (occurred, its intent is not to use as rea	-	

PRINTED: 09/10/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>0MB</u> NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPIJIER/CL/A (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND FLAN OF CORRECTION EDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C B. WING 445286 09/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 FAIRPARK HEALTHCARE CENTER MARYVILLE, TN 37801 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) - TAG-CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F490 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. but provide a retrospective review. This is another mechanism for monitoring the compliance of the visitor and vendor sign in procedure. Results of daily review of the recordings will be reported in the weekday morning meeting. At the present time it is reviewed daily by the maintenance director (Plant Ops Manager) or the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, 3 Business Office Assistants, Activity Director, Activity Assistant, Director of Social Services, Director of Admissions, Director of Medical Records and Data Entry Clerk. It is possible to watch the camera real time if circumstances warrant. The front entrance is locked down beginning at 6 pm. Visitors must ring the bell and security personnel or staff respond to allow visitors to enter and exit the facility. A "visitor's log" placed at the recontionist area is monitored by the security guard to ensure that visitors sign in and out. The Administrator conducted in-services for staff on the facility's updated security measures on August 18, 19, 21, 23, 24, and 28, 2012. Employees on leave of absence, vacation, etc. upon return will receive the same in-service on prevention measures by their department head or designee, prior to reporting to their job area. On August 23, 2012 the District Director of Clinical Operations conducted additional in-service training with Administrator, Director of Nursing, Case Manager, MDS Coordinator, Housekeeping/Laundry Supervisor, Activity Director, Social Worker and Asst. Director of

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRB812

Facility ID: TN0503

members, etc.

Nursing on "Conducting an Investigation on an Allegation of Abuse" which included, but was not limited to, immediacy of investigation, notifications, interviewing alleged victim, alleged petpetrator, interviewing witnesses including staff, residents, family

The maintenance director, Administrator, Business Office Manager or assigned weekend duty managers will be responsible to view the video taping of the front lobby, the employee locker room and the vendor

If continuation sheet Page 14c / 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
TATEMENT OF DEPICIENCIES
(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF COR	RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) f A. BU		IPLE CONSTRUCTION IG	(X3) DATE:	
		445286	B. WI		· · · · · · · · · · · · · · · · · · ·	1	₹- C
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					entrance and report any concerns to the far administrator daily. Any staff member no compliance with enhanced security measured disciplined as appropriate. New hires will facility orientation to the centers enhanced measures. The Facility's Performance Improvement (Administrator, Director of Nursing, Medi Asat. Director of Nursing, Staff Developm Coordinator, Business Office Manager, Rf Manager, MDS Coordinator, Activity Director Social Services, Certified Dietary Mana Ops Manager, Admissions Coordinator, Ups security measures will be provided, effecti measures will be reviewed and further recommendations made as needed. The Administrator/Director of Nursing/Staff De Coordinator will track and trend events as of unknown origin, information from residinterviews and allegation of abuse investig to monitor and evaluate facility's abuse program. The Director of Nursing will compresent to the Facility Performance Improvement to the Facility Performance Improvement Coordinator, Asst. Director of Nursing Medical Director, Asst. Director of Nursing Development Coordinator, Business Office RN Case Manager, MDS Coordinator, Act Director, Director of Social Services, Certifications of abuse that includes a review compliance with the facility's P&P on Abu Prevention & Investigation for review, discrecommendations, if indicated,	tin tos will be receive security Committee cal Director, ent if Case ctor, Director ger, Plant el ton August lates to the veness of evelopment ch as injury pont/family attions, if any, evention cinue to rement sing, Staff Manager, ivity fied Dietary Coordinator) as of	
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· · , == 	TO STATE OF BUILDINGS AND A	Posolete Event ID: XRB812		Facilit	y ID: TN0503 If conting	ation sheet P	99e (44423

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP GODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801				
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SS=E	Investigating an Ab Abuse Act; Conduct Protection of a Res and related notifical Interviews with rand certified nursing stastaff, the Director of Administrator, during had received in-ser procedures for upday Abuse; Responding Abuse; Responding Abuse Allegation; the Conducting an Inversident During an notifications and do The facility remains level until it provides correction and the faculd be reviewed a Assessment/Perforn Committee. 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must maint assurance committee nursing services; a placility; and at least facility's staff. The quality assessment committee meets at issues with respect of the respec	use Allegation; the Elder sting an Investigation; and sident During an Investigation; tions and documentation. Idom facility licensed and stiff, dietary and housekeeping if Nursing, and the lighther revisit, confirmed they vices related to policies and lated security measures; to and investigating an line Elder Abuse Act; stigation; and Protection of a Investigation; and related cumentation. Out of compliance at an "E" is an acceptable plan of acility's corrective measures and evaluated by the Quality mance Improvement BERS/MEET IS tain a quality assessment and se consisting of the director of physician designated by the 3 other members of the	(F 4:		This Plan of Correction is the center's creditallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and it is required by the provisions of federal and the facility policies and procedures the tracility policies and procedures the subject of the deficiencies cited during the 2012 survey. Those policies included governing physician notification, the policies of the 24-Hour Report, the Procediregults, and the abuse policy, abuse conducting an investigation responding and investigation, reporting reasonable suching. Two minor changes were made to policy and procedures. On 8/21/12 an A	correction by the conclusions te plan of ly because id state law, the policy by governing the policy by governing the period of the written to the written to the written	9/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(F 520)	A State or the Sec disclosure of the reexcept insofar as a compliance of such requirements of this Good faith attempt and correct quality a basis for sanction. This REQUIREME by: Based on medical facility investigation program, review of hours, review of an a sexual assault for interview, and review facility's Quality Astronaution type of Demental ability is sexual astronautic for incorrective intervent protected from furth reviewed. The facility reviewed. The facility abuse of one Residents at risk for placed all Residents Jeopardy (a situation of the sexual residents at risk for placed all Residents Jeopardy (a situation of the sexual residents at risk for placed all Residents Jeopardy (a situation of the sexual residents at risk for placed all Residents Jeopardy (a situation of the sexual residents at risk for placed all Residents Jeopardy (a situation of the sexual residents at risk for placed all resident	ements appropriate plans of entified quality deficiencies. cretary may not require ecords of such committee such disclosure is related to the n committee with the is section. s by the committee to identify deficiencies will not be used as	{F 524	This Plan of Correction is the cetallegation of compliance. Preparation and/or execution of does not constitute admission or provider of the truth of the facts a set forth in the statement of deficience correction is prepared and/or exact it is required by the provisions of the constitute as the constitution of the facts of the correction is prepared and/or exact it is required by the provisions of made to clarify the term vision family/friends as well as other provisions such as but not lin E.M.T.'s, Radiological Techs Physicians, Nurse Practitioners, legal representatives. On &/ "Notification" was amended to ach notified for lab test results returned from another laboratory the resident was seen. The Admir services for facility staff on recognizing signs of possible resident. Elder Abuse Act. The conducted beginning on 7/30/8/22/12 and 8/24/12 for facility eare on leave, vacation, PRN wiretum to work until receiving the son August 6 the facility convened Improvement Security Workgrup Director (Plant Ops Manager), Adi of Nursing, Activity Director, Staff Coordinator, Housekeeping Supers Service (Patient Relations) Coordinator, Housekeeping supers Service (Patient Relations) Coordinator, Housekeeping supers Service (Patient Relations) Coordinator, Committee (Administrator, Director Open Jorector of Social Service Manager, Admissions Coordinator delegate responsibility for development Coordinator Coordinator and the proper service action to appropriate members management staff, During this me	this plan of corrections agreement by the alleged or conclusions fencies. The plan of excuted solely because federal and state law. The plan of excuted solely because federal and state law. The plan of excuted solely because federal and state law. The plan of consultants of the plan of excuted solely and state law. The plan of consultants of the plan of the pl		

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NAME OF PROVIDER OR SUPPLIER FAIRPARK HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801			
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(F 520)	participation has ca serious injury, harm Resident). The facility provided Compliance on Aug conducted on Septe corrective actions in 2012, removed the Non-compliance for level citation (potent harm). The findings include Validation of the Cre Compliance was ac record review, facility reviews, and interviews, and i	used, or is likely to cause, in impairment, or death to a dia Credible Allegation of just 30, 2012. A revisit ember 6, 2012, revealed the implemented on August 30, Immediate Jeopardy. F-520 continues at an "E" tial for more than minimal ed:	{F 5	20}	This Plan of Correction is the center's creed officiation of compilance. Preparation and/or execution of this plant does not constitute admission or agreement provider of the truth of the facts alleged on set forth in the statement of deficiencies. To correction is prepared and/or executed soil it is required by the provisions of federal addiscussed and reviewed several of the procedures including physician notification 24-Hour Report, and the procedures for test Medical Director provided clinical input repolicies at that time. The Committee also contains of the action plans for each deficiency. The Performance Improvement (Administrator, Director of Nursing, Medicast. Director of Nursing, Medicast. Director of Nursing, Staff I Coordinator, Business Office Manager, Manager, MDS Coordinator, Activity Director Social Services, Certified Dietary Macops Manager, Admissions Coordinator) as interim, to meet weekly to monitor progress or each action plant. These weekly meanting until the survey team has determined to the Performance Coordinator, Activity Director of Nursing, Staff I Coordinator, Business Office Manager, Manager, MDS Coordinator, Activity Director Social Services, Certified Dietary Macops Manager, Admissions Coordinator, of Social Services, Certified Dietary Macops Manager, Admissions Coordinator, activity Director on a monthly basis thereafter to Facility's progress and to assure that remains in substantial compliance with Requirements of Participation. The Coargred that those individuals who are resoverseeing the corrective action implementations. In the achieved substantial compliance. A met Performance Improvement Committee responsibl	of correction at by the reconcise on the plan of the p	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCIES (X1) PROVIDER/SUPPLIER/GLIA ION IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			<u> </u>			6/2012	
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{F 520}	The facility provided Improvement Commreview the corrective The facility provided Improvement Secur developed to ensure measures were ider Interview with the Arremoval of the Immeremoval of the Immeremov	l evidence the Performance nittee met on weekly basis to e action progress. I evidence a Performance ity Workgroup had been e enhanced security ntified and implemented. Idministrator confirmed upon ediate Jeopardy, the vernent Committee will onthly, or more frequently, as out of compliance at an "E" an acceptable plan of acility's corrective measures and evaluated by the Quality	{F 520}	This Plan of Correction is the center allegation of compliance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts allesset forth in the statement of deficient correction is prepared and/or executif is required by the provisions of fectors are training agendas and or packages to assure that the maconsistent with current regulatory with the Facility's current policies and The Committee has agreed to evaluate every six months.	s plan of correction reement by the gged or conclusions cies. The plan of sted solely because deral and state law, rientation training terial provided is requirements and id procedures.		